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HARINGEY CHINESE CENTRE



Chinese Older People in Haringey: meeting the needs of an 'invisible' community

RESEARCH REPORT

Alessio D'Angelo, Tom Lam, Rosemary Sales

March 2010

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Haringey Chinese Centre

Haringey Chinese Centre has been established in the borough for more than twenty years. It aims to promote and develop social, educational, cultural and welfare services to meet the needs of the Chinese community, to help them in improving their quality of life, and to assist their integration into the wider community by working in partnership with Haringey Council and other local communities.

Website: www.haringeychinesecentre.org.uk

The Social Policy Research Centre (SPRC), Middlesex University

The social policy research centre (SPRC) was established in 1990. It provides a focus for research in the social sciences at Middlesex University and supports high quality research of national and international standing. Members of staff are involved in a wide range of projects funded by research councils, the EU, government departments and the major charities. The Centre supports postgraduate research students, including research funded students and a number of well-established masters programmes. The Centre runs events, including conferences, seminars and short courses. Main areas of interest include: migration, refugees and citizenship, welfare restructuring, governance and risk, urban policy, regeneration and communities, drug and alcohol policy, human security and human rights, tourism policy.

Website: www.mdx.ac.uk/sprc/

Chinese older people in Haringey: meeting the needs of an ‘invisible’ community

Introduction

Haringey has a long established population of Chinese people, some of whom have been living in the borough for many decades. They represent a significant proportion of Haringey’s total population: 1.5% overall but over 2.5% in some wards. Many have become well settled and have been highly successful in business, professions or in other fields but others have experienced exclusion, poverty and isolation. As more of these people are reaching retirement age and beyond, and thus experiencing health and mobility issues connected with ageing, these problems are increasing and are likely to worsen still further in the future. Many of this group also have limited English language skills and thus find it difficult to access appropriate services. In addition, many have low incomes because the nature of their working lives did not allow them to make provision for adequate pensions. In spite of their numbers and the urgency of their needs, Chinese people have had a low profile in relation to the public policy agenda, both in Haringey and in Britain as a whole and have tended to be largely invisible in relation to the planning of services.

This research project was conducted by researchers based at Middlesex University in partnership with the Haringey Chinese Centre and we are grateful for the funding received from the Business and Community Interaction programme at Middlesex University which enabled us to carry out this work. The aims were to provide evidence of current and future needs for health and social care services by Chinese older people and to identify issues which policy makers need to be aware of in planning services. This was an exploratory study and limited in scale and thus we cannot claim that it provides a comprehensive picture of the situation of Chinese older people in the borough. Nevertheless, it identified some important issues which deserve more detailed examination from researchers and policy makers. The project took place during a major process of restructuring of services for older people, arising from both national and local policy developments. We hope that our findings will help to inform the development of these services.

This report begins by describing the study methods used. We then briefly discuss some of the characteristics of Haringey’s population before focusing more particularly on the Chinese population in Haringey and in London as a whole. We discuss first the different waves of migration which have brought a diverse Chinese population and then focus on the problems of social exclusion and isolation. The next section focuses on the elderly Chinese people, their needs, experience and aspirations and use of services. We then discuss the policy agenda in relation to the care of the elderly and its implications for this group. Finally we draw some general conclusions about the need to plan for this group and suggest some recommendations to policy makers, Chinese organisations and other concerned with the welfare of the elderly.

The study methods

Ethical approval was obtained from the Social Sciences Research Ethics Committee at Middlesex University in July 2009 and fieldwork was carried out between July and November 2009. The study used a range of methods including:

1. A review of previous research and analysis of national and local statistics.

- A review of relevant literature included our own previous research on London's Chinese population (see Lam et al, 2009; Sales et al, 2009) as well as other research on Chinese migration patterns, social exclusion, the older population, health needs and use of services.
- The statistics analysed included a wide range of sources, from small area data such as the 2001 Census and the Index of Multiple Deprivation 2007 to the Office for National Statistics (ONS) Population Projections (2008) and Population Estimates (2008). All the data have been elaborated to produce original tables, chart and cartographic outputs. We also further analysed figures coming from the Assessment of Older People's Needs in Haringey report (2009) and other administrative data from the borough.

2. Nine interviews with key informants including service providers in Haringey and people with knowledge of the experiences of Chinese older people. Some of the latter were themselves Chinese people above retirement age. These interviews aimed to explore how participants viewed the specific needs of this group and the extent to which they were taken into account in the planning and delivery of services. In addition, some participants provided evidence of the use of services by Chinese people, both nationally and locally, and the barriers to accessing services. A list of participants is contained in Appendix II.

3. Fifteen interviews with older Chinese people living in Haringey. They included 7 men and 8 women, ranged in age from mid-60s to over 90. They had a variety of migration histories although all had secure legal status. Nine came from China and 6 from Hong Kong. They had all lived in the UK for at least 6 years, and five had lived here for over 40 years. Most spoke Cantonese as their first language. Only one spoke English well and of the others, 10 spoke none or almost none and 4 were able to communicate at a basic level. Further details of the sample are given in (see Appendix III).

The interviews explored participants' everyday lives and focused particularly on their current needs for support and their hopes and expectations of the types of care they would receive in the future. The interviews were carried out in Cantonese or Mandarin, taped and fully transcribed and translated into English

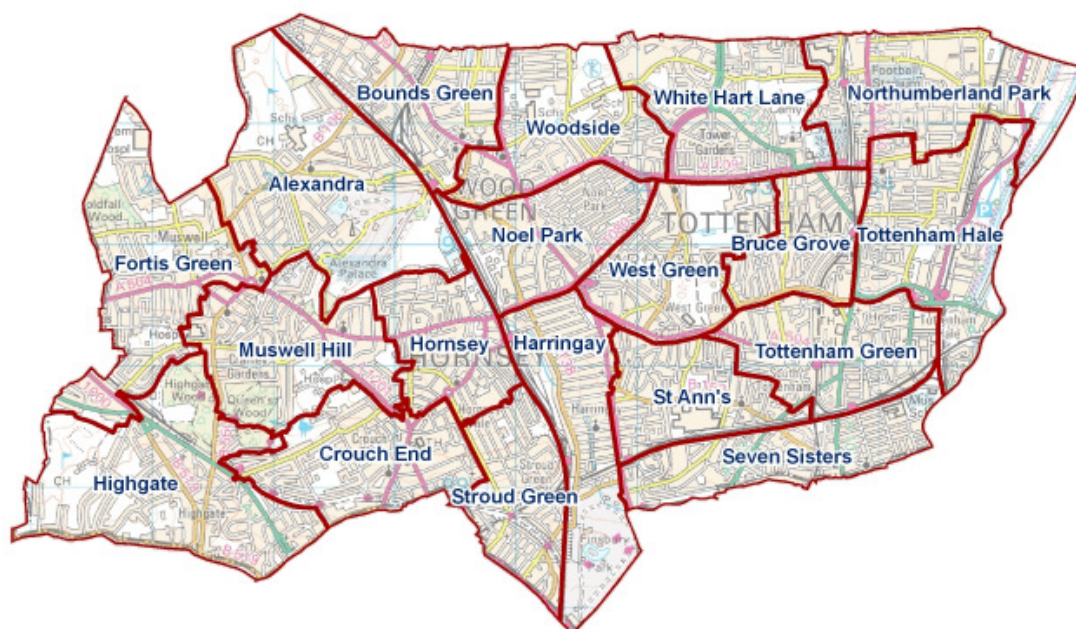
The individual interviewees were all contacted through the Haringey Chinese Centre which played an important role in their lives. Apart from one who was a volunteer, they were all users of the service and needed some level of social care. The majority suffered from various health problems, particularly those that affected mobility, and were fairly inactive. We are aware that many older Chinese people in Haringey do not fit this pattern and are active in a range of activities. Our sample, however, provided us with important data on the needs and experience of Chinese people in the Borough.

The following sections draw on all these data sources in order to discuss the needs of the Chinese older population and their access to services, both at a national level and more specifically in relation to Haringey. The quotations used from the interviews are in italics. The names of individual interviewees have been changed and the initials of key informants are included after the quotation.

Haringey's population: diversity, ageing and care needs

The Council's official website describes Haringey as an 'exceptionally diverse and fast changing borough'. This diversity has many dimensions and is reflected, for example, in its ethnic composition, with 51% of its total population, and 54% of young people, from ethnic minority ethnic backgrounds¹ and around 200 languages spoken in the borough. At the last Census, in 2001 Haringey ranked as the fifth most diverse borough in London.²

Figure 1 - Ward (LSOA) boundaries of Haringey



Map boundaries and baseline: Crown Copyright

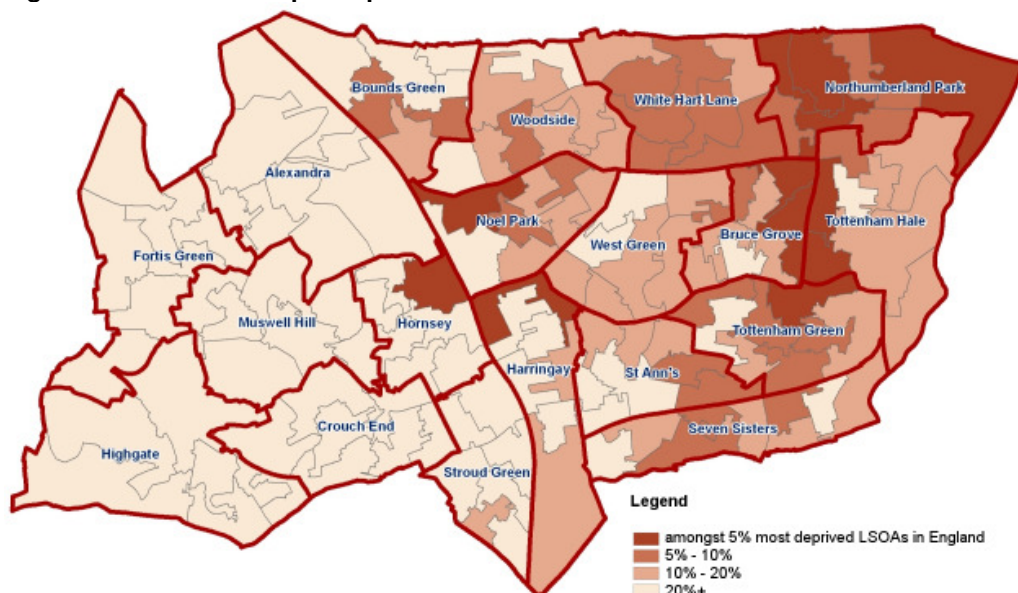
Haringey is also highly diverse in terms of income and social class, with a 'distinct polarisation' between the more wealthy wards to the west and the generally poorer wards in the East. The railway line which crosses the borough from North to South is generally taken as representing the boundary between east and west. This division is reflected in the number of areas which rank high on the Index of Multiple Deprivation (a measure which brings together a number of indicators such as income, employment, health and access to housing). Overall Haringey ranks fifth in London in term of the average 'deprivation score' and nationally at 18, but the areas with the highest level of deprivation are clustered in eastern areas such as Tottenham, Northumberland Park and Noel Park (Figure 2). This division is even more marked when applied to the income deprivation amongst older people (Figure 3).

¹ Source: ONS Mid-2007 Population Estimates

Ethnic minority is used here to include all of those people who identify themselves as belonging to an ethnic group other than 'white British'.

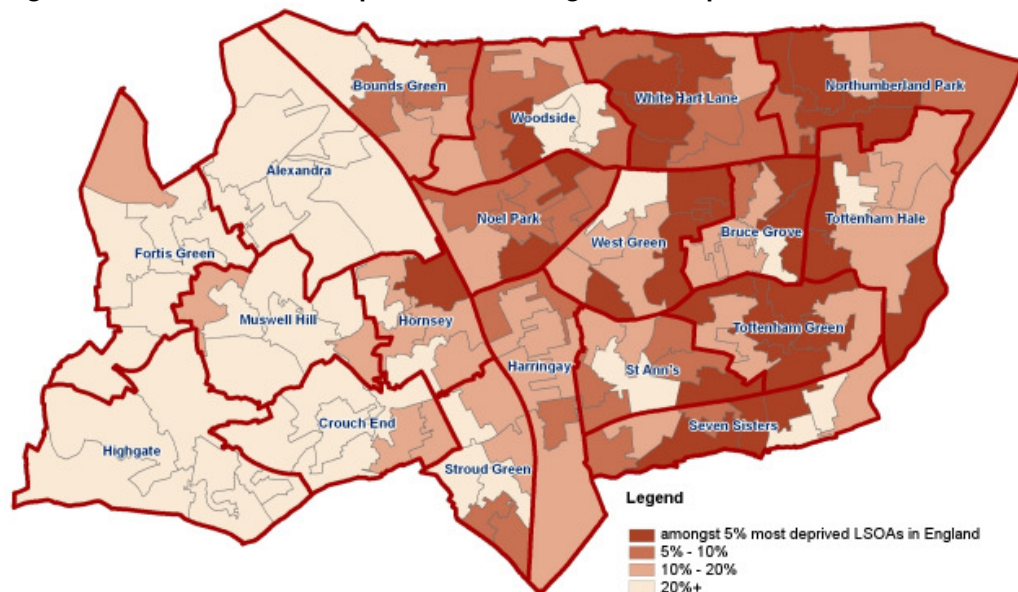
² Haringey has a Diversity Index score of 3.95 compared to a London average of 2.66.

Figure 2 – Index of Multiple Deprivation 2007



Data Source: Index of Multiple Deprivation 2007
Map boundaries: Crown Copyright

Figure 3 – Index of Income Deprivation Affecting Older People



Data Source: Index of Multiple Deprivation 2007
Map boundaries: Crown Copyright

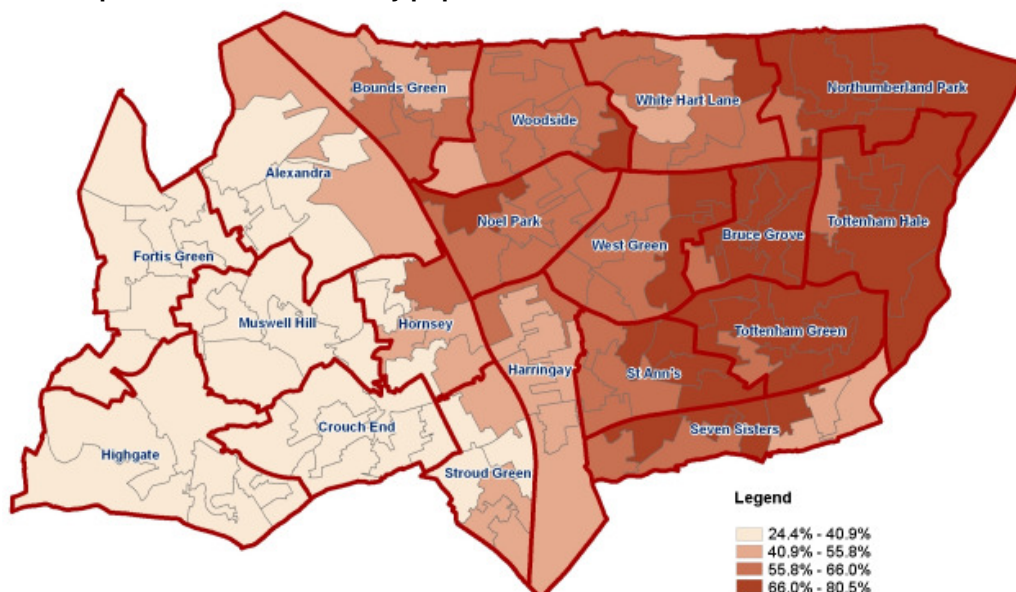
The ethnic composition of the population also varies markedly by ward and Figure 4 reveals a similar east-west division. Table 1 shows that in 2001 the proportion of the population who identified themselves as 'White British' was 45.3% overall, compared with a London average of 59.8%. This figure, however, ranges from 70.4% in Muswell Hill in the west to 28.9% in Northumberland Park in the east.

Table 1 – Haringey 2001 - Population by Ethnicity

	All People	% White British	% Chinese
Alexandra	10,479	65.2%	0.5%
Bounds Green	10,902	44.6%	1.0%
Bruce Grove	11,994	30.4%	1.1%
Crouch End	10,761	66.8%	0.8%
Fortis Green	11,247	67.1%	0.5%
Harringay	10,523	44.3%	1.2%
Highgate	10,311	66.9%	0.9%
Hornsey	10,069	56.2%	0.5%
Muswell Hill	9,979	70.4%	0.8%
Noel Park	11,476	37.7%	1.9%
Northumberland Park	12,599	28.9%	0.8%
Seven Sisters	13,170	36.1%	1.2%
St. Ann`s	12,596	35.0%	1.3%
Stroud Green	10,317	56.9%	0.6%
Tottenham Green	11,969	29.7%	1.5%
Tottenham Hale	12,729	30.5%	1.2%
West Green	11,889	32.1%	2.5%
White Hart Lane	11,992	40.9%	0.7%
Woodside	11,502	39.6%	1.9%
Haringey	216,504	45.3%	1.1%
London	7,172,091	59.8%	1.1%
England	49,138,831	87.0%	0.4%
England & Wales	52,041,916	87.5%	0.4%

Source: ONS, Census 2001

Figure 4 – Proportion of Ethnic Minority population



Data Source: Census 2001

Map boundaries: Crown Copyright

Haringey's population as a whole is somewhat younger than the national average and thus there is a lower than average prevalence of chronic disease (Haringey Strategic Partnership, 2009: 15). The prevalence of disease is however highly variable across the borough, with for example the prevalence of hypertension varying from 8.4% of the population in the west of the borough to 12.4% in Tottenham. The difference cannot be attributed solely to the age structure of the population since the percentage of elderly is fairly evenly spread across wards. Mental health admissions are among the highest in London and are also higher in the east of the borough (ibid: 20.).

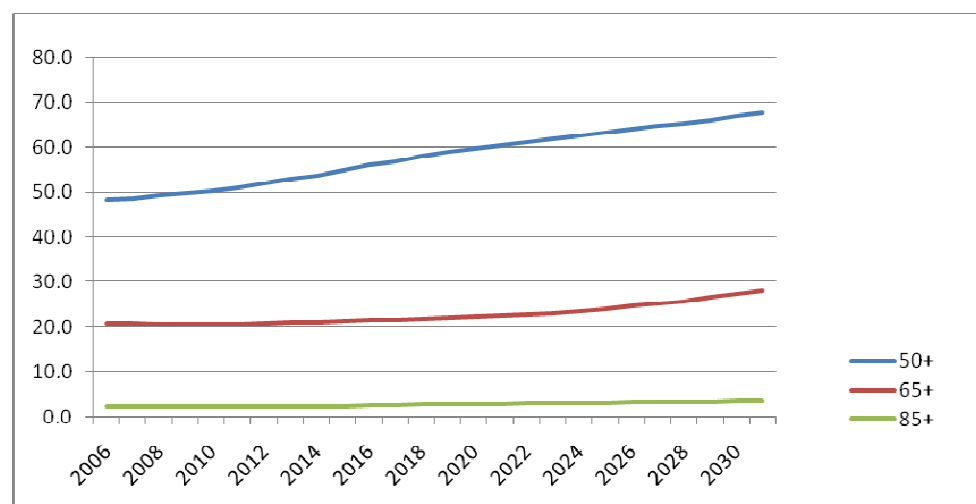
As in Britain as whole, Haringey's population is ageing. According to ONS projections, the borough's population will expand by 9%, or 20,500 residents, by 2029 and the proportion of older people will increase much faster, especially those in the 85 plus age group who numbers are expected to increase by over 50% (Table 2).

Table 2 - Haringey Population Projections by age group (thousands)

	50+	65+	85+	All ages
2010	50.4	20.7	2.3	227.7
2015	54.9	21.5	2.4	232.7
2020	59.6	22.3	2.8	238.2
2025	63.4	24.2	3.2	243.4
2030	66.8	27.5	3.5	248.2
increase 2010 - 2030	16.4	6.8	1.2	20.5
increase %	32.5%	32.9%	52.2%	9.0%

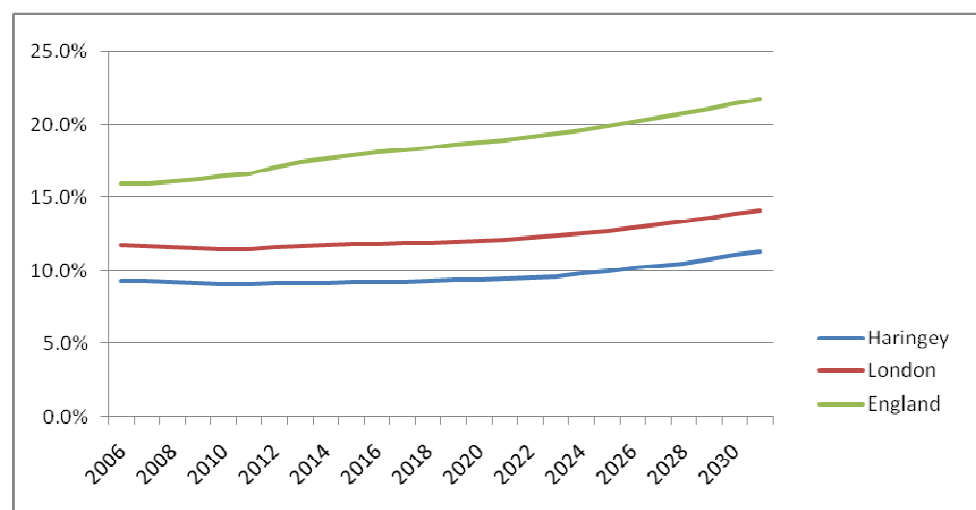
Source: ONS Sub-national Population Projections (2008)

Figure 5 - Haringey Population Projections by age (thousands)



Source: ONS Sub-national Population Projections (2008)

Figure 6 – Projected proportion of population aged 65+



Source: ONS Sub-national Population Projections (2008)

The age structure varies according to ethnicity, with those in the white British category more likely to be of pensionable age (Table 3). This reflects the fact that many in the ethnic minority groups are relatively recent migrants. The difference in the proportions of older people is considerably more marked for Chinese people, especially among men.

Table 3 - Haringey 2007 - Population by age, gender and ethnic group (thousands)

Gender	Age groups	All residents	White British	Non White British	Chinese	% Chinese
Total	All ages	224.7	110.1	114.6	3.5	1.6%
	over pension age	25.0	13.3	11.7	0.2	0.8%
	% over pension age	11.1%	12.1%	10.2%	5.7%	
Males	All ages	112.8	56.1	56.7	1.8	1.6%
	65+	9.1	4.7	4.4	0.1	1.1%
	%65+	8.1%	8.4%	7.8%	5.6%	
Females	All ages	111.9	54	57.9	1.7	1.5%
	60+	15.9	8.6	7.3	0.2	1.3%
	%60+	14.2%	15.9%	12.6%	11.8%	

Source: ONS, mid-2007 population estimates (experimental statistics)

According to a national report on the funding of social care, the *Wanless Report* the increase in life expectancy which these figures reflect has not been accompanied by an increase in 'healthy life expectancy' (Wanless, 2006; see also Ryan et al., 2009). Thus a growing number of people will need some form of medical and social care over an extended period as a result of illnesses which are more prevalent in older people as well as the loss of mobility, general frailty problems with sight and hearing which may accompany ageing.

Haringey Strategic Partnership (2009) calculated the possible increase in some major problems associated with ageing. Their figures are based on ONS population projections and assume that the proportion of each age group experiencing these problems remains the same. Table 4 shows an estimated increase of over 2,000 people with Limiting Long Term Limiting Illness (LLTI)³ over the next 15 years with the percentage increase particularly marked in the over 85 age group.

³ Limiting Long Term Illness is a term used in the census and defined as a 'Limiting Long Term illness or disability which restricts daily activity. Like all Census data, the figures are based on self-reporting.

Table 4 - Haringey - People aged 65+ with a limiting long-term illness, projected to 2025

Age group	2008	2010	2015	2020	2025	Projected Increase
65-74	5,186	5,097	5,186	5,499	5,991	13.4%
75-84	3,794	3,849	4,123	3,959	4,178	9.2%
85 and over	1,413	1,413	1,474	1,720	1,966	28.1%
Total 65 and over	15,579	15,455	15,970	16,677	18,126	14.1%

Source: Assessment of Older People's Needs in Haringey (2009: 19)

We calculated the proportion of the population reporting a LLTI by ethnic group from 2001 Census data (Table 5). This shows that, although a slightly higher proportion of those in the non-white British category report a LLTI than the overall population, there is a significantly lower proportion for Chinese. This may partly reflect the different age structure of the population, but it should be born in mind that the category is based on self-reported illness and may be affected by different cultural traditions in relation to response to illness. Another study found marked differences in reported LLTI by ethnic group which could not be explained by other factors (Sales and D'Angelo, 2008).

Table 5 - 2001 - Population by Ethnicity, Limiting Long Term Illness and General Health

	Haringey			England & Wales		
	All residents	Non White British	Chinese	All residents	Non White British	Chinese
All people	216,507	118,479	2,444	52,041,916	6,508,175	226,948
With a LTLI	33,590	17,969	203	9,484,856	915,097	17,832
% with a LTLI	15.5%	15.2%	8.3%	18.2%	14.1%	7.9%
Not good health	19,373	10,865	126	4,797,343	522,725	9,288
% not good health	8.9%	9.2%	5.2%	9.2%	8.0%	4.1%

Source: Census 2001, TT-13

The number of people over 65 with dementia is predicted to rise by over 300 in the same period, an increase of 19% (Table 6). Dementia is strongly associated with ageing and nationally one in four people over 85 suffer from the disease (Haringey Strategic Partnership, 2009: 19). This group has particularly high needs for support since the disease gradually reduces people's ability to care for their every day needs.

Table 6 - Haringey - People aged 65+ with dementia, projected to 2025

	2008	2010	2015	2020	2025	Projected increase
Males	459	490	520	587	637	27.9%
Females	849	852	864	905	986	13.9%
Total	1,309	1,342	1,384	1,492	1,623	19.3%

Source: Assessment of Older People's Needs in Haringey (2009: 20)

Table 7 gives alternative predictions for the increase in depression among older people, with both the higher and the lower estimates suggesting that it will rise by 14%. Depression is particularly prevalent among older people for whom social isolation and lack of physical activity can be contributory factors. In Haringey the level of physical activity of older people is low with 90% of those over 65 reporting that they had taken no exercise in the past week (Haringey Strategic Partnership, 2009: 22).

Table 7 - Haringey - People aged 65+ with depression, projected to 2025

	2008	2010	2015	2020	2025	Projected Increase
lowest estimated level of prediction	2,080	2,070	2,150	2,230	2,420	14.0%
highest estimated level of prediction	3,120	3,105	3,225	3,345	3,630	14.0%

Source: Assessment of Older People's Needs in Haringey (2009: 20)

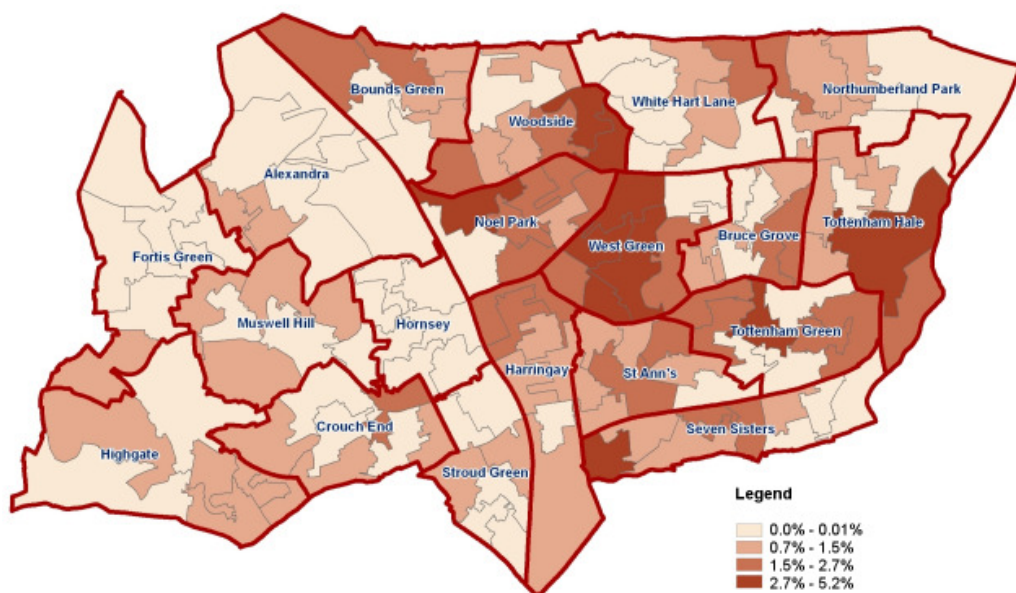
The changes associated with an ageing population will disproportionately affect Black and Minority Ethnic groups such as the Chinese over the coming years. For many, large scale migration to Britain began during the 1950s and 1960s, generally for work or to join families, and they are only now approaching old age and the issues which it brings with it. They bring specific needs in relation to social care services, for example in relation to language and food, and the prevalence of certain diseases is higher among some ethnic groups (see e.g. Aspinall and Jacobson, 2004; Moriarty and Butt, 2004; PRIAE, 2005). At the same time many have not acquired adequate English language skills, or lose these as they get older, and therefore experience difficulty in accessing services. This is particularly problematic in relation to diseases such as dementia where early intervention can improve quality of life considerably.

The figures reviewed here suggest that policy makers need to be proactive in seeking to respond to the current and potential needs of its diverse population. These issues have been central to recent policy documents aimed at analysing these needs and exploring policy responses within the borough (policy documents). These do not, however, mention the Chinese population specifically and their particular issues and needs. The following section explores in more detail the characteristics of this population, drawing on information at both the national and specifically Haringey levels.

The Chinese Population in Haringey

Chinese people make up a significant proportion of Haringey's population, representing 1.6 % of the total (see Table 3) compared to a national and London average of 0.8% and 1.5% respectively. Figure 7 also shows that areas with the highest Chinese population are in the east of the borough (which also has higher levels of deprivation. The population is, however, spread across the borough, making up at least 0.5% in each ward.

Figure 7 – Chinese as Proportion of total population



Data Source: Census 2001
Map boundaries: Crown Copyright

Table 3, based on 2007 population estimates, showed that the proportion of Chinese people in the post-retirement age group is currently lower than that for other ethnic groups, reflecting their relatively recent settlement. Overall, the Chinese population in Haringey is estimated at around 3,500 people, of whom about 200 are over pension age. Table 8 (based on the Census) indicates that, although in 2001 Chinese people made up only 0.8% of the population aged over 65, they were 1% of the over 50 group (with 179 and 488 Chinese people respectively). Thus the total of Chinese aged over 65 is likely to rise considerably over the next 20 years as their numbers are swelled by those now approaching retirement age. The table also shows a high concentration of the elderly in West Green ward where they make up almost 4% of the total population.

Table 8 - Haringey 2001 - Population by Age Group and Ethnicity

Area	People Aged 50+			People Aged 65+		
	All People	% White British	% Chinese	All People	% White British	% Chinese
Alexandra	2,640	68.4%	0.7%	1,015	68.0%	0.9%
Bounds Green	2,655	53.6%	0.6%	1,310	62.1%	0.5%
Bruce Grove	2,459	37.3%	0.7%	1,078	44.2%	0.6%
Crouch End	2,457	68.1%	0.9%	1,004	68.2%	1.2%
Fortis Green	2,977	74.8%	0.6%	1,395	79.5%	0.4%
Harringay	2,141	35.8%	1.0%	983	36.4%	1.0%
Highgate	2,668	72.9%	0.7%	1,219	76.0%	0.2%
Hornsey	2,237	60.6%	0.7%	990	62.8%	0.6%
Muswell Hill	2,745	75.1%	0.7%	1,112	77.4%	0.8%
Noel Park	2,599	42.8%	1.4%	1,138	52.4%	0.7%
Northumberland Park	2,563	47.1%	0.8%	1,182	59.8%	0.8%
Seven Sisters	2,617	39.7%	1.1%	1,137	45.4%	0.9%
St. Ann`s	2,812	38.2%	1.5%	1,290	46.6%	1.3%
Stroud Green	1,897	51.6%	0.7%	689	46.0%	0.4%
Tottenham Green	2,484	39.6%	1.4%	1,053	46.5%	0.8%
Tottenham Hale	2,560	45.3%	0.9%	1,094	57.8%	0.5%
West Green	2,512	38.8%	3.1%	992	46.9%	3.8%
White Hart Lane	2,634	65.1%	0.4%	1,290	77.3%	0.0%
Woodside	2,632	47.6%	1.4%	1,201	56.7%	0.9%
Haringey	48,289	53.2%	1.0%	21,172	59.2%	0.8%
London	1,908,291	72.4%	0.7%	891,590	78.3%	0.5%
England	16,367,958	92.1%	0.2%	7,808,000	93.4%	0.1%
England & Wales	17,410,844	92.4%	0.2%	8,312,774	93.6%	0.1%

Source: ONS, mid-2007 population estimates

The wide geographical spread of the Chinese population, and the different age profiles in different wards, reflect the different waves of Chinese migration to Britain. In the next section we briefly discuss the major features of Chinese migration to London.

Chinese Migration to London

London's Chinese population dates back over 150 years (Owen 1994; Chan & Chan 1997) and now includes a substantial British-born component. People of Chinese origin have continued to come to Britain through the period since then but there have been a number of important waves of migration which have brought new groups with different regions of origin, social background and reasons for moving.

Many of the first settlers were sailors who started to arrive in the second half of the nineteenth century and settled mainly in the Limehouse area close to the docks, where London's first 'Chinatown' became established. Following the Second World War and colonial restructuring in China, a new wave of migration developed from Hong Kong and the New Territories. These new migrants, whose numbers peaked in the late 1950s and early 1960s, were predominantly male, generally spoke little English and were mainly Cantonese speakers. They provided a cheap supply of labour for businesses in the new Chinatown developing in the Gerard Street area of Soho in Central London. As Chinatown prospered Chinese workers started to bring their families to join them and many moved out of Chinatown to establish businesses in other parts of London and across Britain. Some moved to Haringey, attracted in particular by the lower property prices in the east of the borough. Once they were established, the existence of Chinese shops and services brought others. As one of our individual interviewees, Mr Man, explained:

[Haringey] it's not the best place you can find [but there is a large Chinese population] because the property prices were lower then. It wasn't the dearest place to live in those days; Chinese people were able to afford rents there. That's why most Chinese people live here. (Mr Man)

The next major wave of Chinese people consisted of refugees from Vietnam who arrived during the 1970s and 1980s, a large proportion of whom were ethnically Chinese (Lam and Martin, 1997). Chinese people also migrated for study and work in increasing numbers from neighbouring countries such as Singapore and Malaysia which have substantial Chinese population.

The largest group of new arrivals during the 1990s and 2000s have been from mainland China. Emigration from China was made easier following the economic and political reforms from 1978. Most of those who came during the 1980s were sent by the Chinese authorities or educational institutions although some later applied for political asylum after events such as the Tiananmen Square protest in 1989. The flow of highly skilled migrants has increased as Britain's trade with China has expanded (Pieke 2004). At the same time, the unevenness of Chinese economic expansion has meant that some areas have suffered declining income, compelling many to leave in order to seek a living for themselves and their families elsewhere.

A large proportion of these newer migrants have insecure immigration status. Some have over-stayed their permission to stay while others entered the country without documentation. Increasing restrictions on the entry of people from outside the European Union have meant that many people rely on smugglers and work illegally in Britain (Sales, 2007a). The problems which they experience received widespread publicity following the Morecambe Bay Tragedy of 2004, when 23 Chinese cockle pickers were killed as they worked in dangerous conditions. It is often assumed that this group is predominantly male, but many Chinese women have also entered in this way (Song, 2004: 138). Moreover, some are already in their 40s or 50s when they travel, often seeking to support families back in China (Lam et al, 2009).

Some new entrants claim political asylum but the proportion of applicants granted refugee status has fallen to less than 10 percent as Britain was sought to improve its relations with the Chinese government (Lam et al, 2009). Many people who are undocumented or whose asylum applications have been rejected ('failed asylum seekers') remain in Britain for years, their legal status and lack of English preventing them from getting decently paid jobs, while their inability to earn enough money to pay the large sums they have spent in reaching Britain makes it impossible to return home. They are thus in a form of limbo, unable to leave but not in a position to take the first steps towards integration into British society.

London's Chinese population has thus become increasingly diverse. As well as new migration, family members of people already established continue to arrive, with both spouses and children and elderly relatives entering through family reunion. This diversity means that the elderly population, and those approaching retirement age, come from a variety of backgrounds, regions of origin and migration histories. These create a number of divisions which can impede communication and cooperation. Most of the older migrants are Cantonese speakers, but newer arrivals from China are more likely to speak other languages such as Min-Nan, the dialect spoken in the Fuzhou region. They may be able to speak Mandarin, but for most this is not their first language. Language barriers may mean, for example, that they are not able to seek help from Chinese community organisations which were largely set up in order to serve the needs of the Cantonese speakers. New arrivals tend to rely on 'guanxi', personal relationships often with people from the same region, in order to find employment and housing (Lam et al, 2009). In addition the different forms of migration can serve to undermine trust between new arrivals and the established population. The undocumented status and poor living conditions of many new arrivals may make them unappealing to established migrants. Some established groups have sought in particular to distance themselves from asylum seekers as Chinese community organisations have formed closer ties with the government of the People's Republic of China (PRC) (Sales et al, 2009).

Our respondents reflected some of this diversity although all had been in Britain for at least five years and they all had permanent residence status. Mr Man, who had lived in the UK for 40 years

and in Haringey for 30, came from Hong Kong to which he fled during the Second World War, while others had come much more recently. Most came to Britain to work but several, mainly women had come for family reasons. This was not always a choice they had made themselves. Mrs Fong explained how her decision about her own working life was affected by family obligations.

I retired when I was fifty years old. I took early retirement. ... I didn't really want to take early retirement but my daughter wanted me to look after her children for her [so I retired] and came here. (Mrs Fong)

One man, Mr Cheung, also came originally to help his son in his business, moving to Ipswich, in 2003 to join his son:

He was running a restaurant there. I helped him with a bit of this and that, kind of general duties, buying food, ordering kitchen provisions and things like that. When his business became more established, I left to move here [to London]. (Mr Cheung)

An invisible community?

In spite of their growing numbers, Chinese people in Britain have remained relatively silent in relation to public policy and are largely invisible on the policy agenda both nationally and locally. They are not perceived as a 'problem' and make few demands on services. As one key informant, a former teacher, put it: '*Chinese children were never any trouble, always did their homework, they did well so you didn't notice them*' (TM). Another key informant, who has campaigned for many years to raise the profile of the Chinese community, suggested that Chinese organisations have not been seen as part of the minority ethnic population in relation to service provision. As she put it '*we are the minority of the minority*' (SPL). Moreover, in spite of visible concentrations of Chinese presence in Chinatown, the population as a whole is highly scattered across Britain, a pattern reflected in London and Haringey.

No organisation has succeeded in providing a consistent national voice for Chinese people in Britain and their needs therefore tend not to be taken seriously into account by service providers (Yum 2001: 7). Chinese people have tended to come together only in relation to specific events rather than developing more long term campaigns. Such events have included the Foot and Mouth outbreak in 2001 when Chinese campaigners forced the Minister of Agriculture, Nick Brown, to apologise for insinuations in the media that Chinese restaurants were responsible for the disease; and the immigration raids on Chinatown in 2007 which brought together a range of individuals and organisations with a stake in Chinatown. There are a large number of local Chinese centres across many parts of Britain where there are significant Chinese populations but the links between them are often limited. The engagement of Chinese people in mainstream British politics has also tended to be low. As AT explained:

We have never had a national figure, no MP. Notwithstanding that the Chinese is one of the largest immigrant communities in the UK. ... nobody articulated the Chinese aspirations on a national level. Unless we can unite together, have a common voice, people are not going to take us seriously. (AT)

Lord Michael Chan, who died in 2006, became a peer in 2001, but there has been no Chinese member of the House of Commons. Indeed, Anna Lo who was elected in March 2007 to the Northern Ireland parliament was the first ethnic Chinese person to be elected to a parliament, not only in Britain but in the European Union. There are few Chinese local councillors and few have developed a high public profile, although Thomas Chan became Britain's first Chinese mayor in 2009 in the borough of Redbridge. This invisibility is replicated in Haringey where the Chinese population remains largely absent from public debate. There are no Chinese councillors in the borough and in the two wards with the largest Chinese population there are no Chinese members of the Labour Party (the party to which all but one of the borough's councillors belong). Other groups such as

Cypriots, Irish and African Caribbean are more visible in the political life of the borough, with substantial numbers on the council and in local political parties. As one key informant, responsible for developing health policy, said of the Chinese, '*their voices are not being heard*' and they are not noticed as much as they should be given the size of the population. As RE put it, '*there is even an absence of recognition of the gap in planning*' of the culturally specific services which will be required in the future.

In spite of its generally low public profile, the Chinese population in Haringey has a major resource in the Haringey Chinese Centre which has been established for more than twenty years. It was founded in 1987 with a grant from Haringey Council which enabled the group to buy premises near Turnpike Lane, in the ward, West Green, with the highest concentration of Chinese people in the borough. The Centre now has around 600 members and provides a range of services, including a Chinese Saturday School, a women's group, a drop in advice service as well as day care and a luncheon club for older people (Bell, 2008). The Centre is conveniently located for its users, near the Piccadilly tube line which goes directly to Chinatown. As Mrs Yuk explained:

I have been living here for over 20 years [...] I like it here. I am happy living here. It's convenient for travel. [...] It's convenient for Chinatown too. (Mrs Yuk)

Chinese people have thus gained some visibility in the areas. The fact that the Centre has been established over such a long period means, however, according to RE, that there can be a tendency for service providers to think that it can deal with all the problems that arise for Chinese people. Thus the specific needs of Chinese people remain excluded from the mainstream planning of services.

Social exclusion and the Chinese population

The perceptions of the Chinese population have undergone many changes since they first started to arrive in Britain during the colonial period. According to Parker, 'stereotypes of Chinese people reflect the 'recurrent fascination and repulsion with which the West has conceived of the East' (Parker, 1998:67). The first migrants encountered both popular hostility and discrimination. Contemporary accounts of Chinese people 'frequently referred to their exotic or potentially provocative habits such as opium taking, gambling and sexual relations with 'white women' and girls' (May, 1978: 111). The *Aliens Act, 1905*, Britain's first legislation to control immigration, although mainly targeting Jewish immigrants was also used against Chinese people (Holmes, 1988: 80).

Thus Chinese people initially faced extreme exclusion but as they became established during the 1960s, perceptions changed and they began to be viewed as a 'model' community (Wong, 2003). According to the last Census, for example, Chinese children were the highest achievers of any ethnic group in school examination results (ONS, 2005), while Chinese people do well on socio economic indicators such as income and employment (Song, 2004: 869). They are perceived as making little claim on the state, for example in relation to welfare benefits (Chan et. al. 2004: 1; Chan et al, 2007). A Report to the Home Affairs Committee in 1985 reinforced that stereotype:

It is mainly family oriented and hence many of the traditional Chinese values still hold. ... lack of lobbying on behalf of the community at local government or national level, not asking anything from the host community has led to this introversion.
(Home Affairs Committee, 1985: 14, cited in Chau, 2008: 2)

With the institutionalisation of London's Chinatown in 1985 in a ceremony addressed by the Mayor of Westminster and the ambassador of the PRC, the Chinese became the 'acceptable' face of multiculturalism, a status which was enhanced with the promotion of Chinese events during the build up to the Olympics. The increase in undocumented migration has, however, threatened this 'carefully built image of Chinese ... and jeopardise the political goodwill and influence that the Chinese have in

the receiving society' (Pieke, 2005: 27). These new arrivals have also reinvigorated 'orientalist' stereotypes, and associations with illegal activities.

Research has also suggested that, in spite of the image of economic success, the experience of Chinese people living in Britain is much more mixed, with high levels of social exclusion and social isolation which is masked by the average figures. This social exclusion is prevalent among long established migrants (see e.g. Chan et. al. 2004; Chan, 2002; Chau and Yu, 2002) as well as newer arrivals (Lam et al, 2009) and may often be particularly severe among older people (Chiu, 1989; LCCA, 2002; Yu, 2000) . This history of migration and settlement has created the conditions for extreme isolation not only from British society but also from other Chinese people.

Many people who migrated to Britain during the 1950s and 1960s came from peasant backgrounds in Hong Kong and the New Territories and were poorly educated. They found work in catering and, because of the long and unsocial hours, often had little opportunity to learn English. Women faced a double burden, often working in restaurants as well as taking responsibility for the family (Song, 1995). As one key informant put it:

Many of them worked in the restaurant as kitchen helpers, washing up, cleaning. They were unskilled. As well as that they had to look after the home and raise the children so their tasks were much harder than a man's. (AT)

As they became more established, Chinese people moved out of Chinatowns and set up restaurants and takeaways across Britain. While some prospered, others struggled to survive. Employment in family business meant that there was a low level of take up of benefits although in some cases the income derived from the business was not sufficient to support all those notionally working there (Yu, 2001:5). The long hours could lead to work related health problems such as arthritis (Yu, 2000; Lam et al, 2009). Yu (2001: 4) found that middle aged and older workers suffer from health problems often leading to premature retirement. This was the case for one of our interviewees, Mrs Ying:

I mainly worked at washing dishes, both in Chinese and Westerners' restaurants. I retired when I couldn't work anymore because of age and bad health. I can't walk now. (Mrs Ying)

Mrs Mui blamed her husband's early death on overwork:

[My husband] worked so hard after coming here. The workload was so heavy that eventually he died. The restaurant business in those days was good but kitchen workers were only paid £9 a week and you had to work long hours. (Mrs Mui)

The nature of the restaurant market meant that – outside the big concentrations of Chinatowns – Chinese people had to set up their businesses at a distance from each other so that they did not compete for the same clientele. Chau and Yu (2002) suggest that the focus on individual enterprise isolates many from their own communities as they struggle to secure their market position within a competitive world. This necessitates long hours of work which restricts their opportunities for social interaction (Song, 1999). Competition is intense with profit margins low, reducing the incentive to build relations based on trust with those in similar business. The diversity of the Chinese population, in terms of language, religious belief and place of origin, also undermines the basis for strong community loyalty.

The Chinese population also lacks a focus for regular community interaction such as are provided for other groups by religious institutions such as churches or mosques or for example by political or cultural organisations. A minority of Chinese people are Christian and Chinese churches can be important places of support for some Chinese people. Those who celebrate traditional Chinese religions tend to worship in their own homes, and rarely visit places of worship. Chinatowns play an important practical and emotional role in the lives of many Chinese people, particularly newcomers (Sales et al, 2009) but they do not necessarily provide a focus for maintaining and

building personal connections. Many go to celebrate family occasions and traditional dates but these are exceptional rather than part of everyday life (Yu, 2001: vi). Most of our respondents had a narrow circle of friends, almost all of them Chinese but they seemed reluctant to become too engaged with them and often stressed their need to maintain independence. Mrs Ma said she was no longer in touch with her friends, explaining '*I am kind of a self-supporting person. I am not too dependent on others.*' Mrs Lau described meeting occasionally for dim sum, but she said.

But all of them are busy with their own things. They have their family life as well. Some of them might look after their grand-children. So they don't have a lot of time to be with you or go out and meet you for Dim-sum.
(Mrs Lau)

The long hours worked by the older generations of Chinese people also meant that they often had little time to spend in leisure activities or with their children and children often had little opportunity or inclination to learn Chinese, especially written Chinese. Li Wei, in a study of language use among Chinese people in Tyneside, found that it is typified by a strong polarisation, with the older generation often remaining monolingual in Chinese even after many years in Britain while their British born children are overwhelming inclined to speak English. This is a reflection of their lack of strong social networks among Chinese people due to the dispersion of the younger generation may have has a Chinese language as their mother tongue but retain only a 'minimum and passive knowledge of it' (Li Wei, 1994:181). Thus children may not pass on Chinese languages to their children and grandparents are unable to communicate with grandchildren.

Moreover, having achieved higher education they are often unwilling to enter the family business and prefer professional occupations. This can lead them to become distant from their families both geographically and socially. Changing family structures and the pressure of work means that family members are often unable or unwilling to provide for the care of elderly members. A study in Liverpool for the Chinese National Healthy Living Centre found that most elderly people lived alone rather than with relatives. According to their report 'the responses shattered the stereotypical image of caring and supportive extended families in this group' (Mind, 2006). Yu's study of older Chinese people found that many saw their children rarely (2001: 10). Chan et. al. (2007) however, argue that Chinese people remain family-orientated and self-reliant with low expectations of public welfare. This issue was a strong theme in our study as one key informant explained:

I suppose isolation is probably more predominant among the Chinese elderly. When they first came here their ambition was to earn enough money, send it home to their parents who looked after the children and when they got more established to bring the children over. Now the second generation of Chinese have mostly done quite well – high achievers, became the professionals, lawyers, nurses, doctors, accountants, but with this kind of professional jobs, mobility is greater. (AT)

These issues were reiterated in the interviews with individuals. As Mr Man, who had worked in catering, said:

I'm also lucky in this. I can't say that I have made lots of money, but my children are doing excellently in education. My children went to Cambridge University. (...) They are in the financial investment business. They make lots of money. (Mr Man)

This success means, however, that children have less time to be with their elderly parents. Most respondents seemed to accept that their children's lives were very different from their own, and this statement from Mrs Lan was fairly typical:

My daughter is working. She can't find the time so easily. She is busy. Everyone is busy working. No one has time to be with you these days. (...) My grandchildren are busy working too. They have to work. They can't just leave work and go out with me. (Mrs Lan)

While most of our respondents seemed to accept this change from traditional behaviour, some like Mr Wong felt angry with their children:

Do you know why I don't want to stay with my children? Because today's young people have a different way of doing things. Whenever I say something that they don't want to hear, they would turn away their face. It's irritating. Young people don't want to live with their parents. They don't like staying with their parents. They liked you when they were still young. When they were young they need you. They'd say: 'Daddy, I wanna go McDonalds!'. But when they are grown up, they don't want to stay with you. They'd say to you: 'Get out!' (Mr Wong)

Chinese older people thus often experience high levels of isolation both from their families and the wider Chinese population. At the same time they often find it difficult to integrate and make meaningful contacts with the wider society, especially because of language and communication difficulties. According to one estimate 70-80% of Chinese and Vietnamese people are unable to speak English with any confidence (Mind, 2006). Many face severe difficulties in learning English:

The first generation were mainly peasants from the New Territories and Hong Kong. They didn't speak the language and the majority of them could not read or write Chinese let alone English. So it's very difficult to learn; plus the fact that they did not have any opportunity whatsoever, coming over and working in the catering trade and laundry, unsocial hours, very long, so they didn't have any opportunity to integrate or to learn the language. And working with people of the same ethnic background, they spoke Hakka or Cantonese. (AT)

Women are less likely to speak English and therefore experience greater social isolation (Baxter & Raw, 1988; Song, 1995; Lee et al. 2002). Many who came from Hong Kong and the New Territories during the 1950s and 1960s were illiterate in their own language.

Chinese as you know is a male chauvinist society. Men at least had the basic education, primary or if they were lucky secondary school. Whereas women born in the 1920s, 30s or 40s never or seldom were sent to school unless the family was well to do. (AT)

The fundamental differences between Chinese and European languages make it difficult for Chinese people to learn English. Chinese writing is based on pictograms and English script thus looks completely alien with no point of reference which Chinese people can recognise. They may not recognise the numbers or the alphabet, so that – though may be able to travel locally and get to Chinatown - more complex journeys are not possible. One of our respondents, Mr Lau, felt that he should have done more to learn English:

I should have learnt a bit of English over the years, as I more or less had the chances to meet with customers and those who contacted us through business ... But then I have not been able to learn anything substantial. I consider this as a failure [in my life]. (Mr Lau)

Others seemed to accept their lack of English and the restrictions which it imposed. Mr Wong wanted to be friendly towards his neighbours but had to find other ways of showing this:

All I can say is 'Hello', 'Good morning', 'Good night' and things like that. Sometimes they want to ask me to come to their house; and sometimes I want to ask them to come to my house, too. But I don't speak English well enough to say more than that. So once when I had money in my pocket I bought a piece of pork from the market and roasted it in the oven and gave them a piece. That's how we get along. (Mr Wong)

Others, however, were more reluctant to interact with westerners, feeling that they faced racism. Mr Chow felt: *They may not say it loud, but they bully you from the inside; in the way they are thinking, they bully you.*

The problems of ageing

The experiences described above mean that many Chinese people are ill-equipped to lead healthy and independent lives when they reach retirement age and they lack the wider support networks which help keep them active and allow them to access the services they need.

The social worlds of our respondents had shrunk since they retired, particularly for those who now lived alone. For some the Chinese Centre was the main place where they socialised. Mr Wong said he visited other friends in their homes, but for Mr Cheung, his friends were in the Centre: *'we meet and we talk for a laugh. So in a way they are my friends.* Mrs Fong said *'I don't have many friends anyway. You see these people here (in the Centre) are my friends [laughs]. You see. They are my friends here [in this country].* Mr Chow was reluctant to maintain contact with people he used to work with, apparently fearful of putting them to any trouble:

How can you meet them? No one is free [...] If you went there to see them, they might have to spend time with you? They might have to entertain you and treat you to a meal. That could cause inconvenience, because they might have work to do. So you just feel reluctant to go. (Mr Chow)

Most lived fairly limited lives as Mr Lau described his day:

There's nothing really special about it. I'd go out a bit each day; I do window shopping, I do a little bit of sightseeing, I go here and there and that is it. Basically I just go out for a walk to see things outside. (Mr Lau)

Most of them appeared resigned to this solitary life. As Mr Ma said:

I am used to a tranquil lifestyle. I am used to a bit of quietness. [...] I read a bit of books when I have time; I read newspapers; I watch TV; I go to the park for a walk and so on; and I don't feel too lonely. I'm used to it. (Mr Ma)

They often saw little of their family. Asked if her son came to see her often, Mrs Yuk said:

He has to work. He is busy with work. My daughter has her own family as well. She has to take her children to school and then pick them up every day. She is busy, too. She has to take care of her kids as well (Mrs Yuk)

Social isolation affects physical and mental well-being. Most of our respondents suffered from physical ailments which affected their mobility, further reducing their ability to socialise. Mrs Ying finds it an effort to walk and uses a stick. As she said *'Without the stick I cannot even take a step.'* Some of these health problems had been worsened by hard working lives. Chinese people tend to see themselves as old and were resigned to becoming less mobile. As Mr Lau said:

I have a bit of problem with my health. You see, I am not a young man anymore. How can I be free of any ailment? It's not surprising for people like me to have a bit of problem, especially at my age. (Mr Lau)

None of our respondents talked specifically about mental illness but some appeared to be quite depressed about their lives. Mrs Chan said:

Yes, I'm bored. That's why I come here [to the Haringey centre]. And when I go back [to the sheltered housing scheme] I will go to bed. I have a cup of tea and go to sleep. You can't take public transport [it's not safe]. So even if you get free travel it's useless. (Mrs Chan)

Others described conflict with their children and feelings of being a burden. Mr Cheung lives with his daughter but does not feel comfortable with the situation:

I'm basically living under someone else's roof [...] Our relationship is very bad. [...] I don't feel happy. I look happy in the outside; I tend to put on a smiling face most of the time. But deep down I feel sad. I feel bad. [...] She doesn't like me living there with her. She really wants me to move out. She thinks I am giving her too much trouble living there. [...] Now that I'm getting on age, and have moved to the UK, my daughter is beginning to feel that we are a burden. (Mr Cheung)

This corresponds to the findings of Yu's study of older Chinese people (Yu, 2001). Many of his participants had a low self-image and over half of the 100 older people he interviewed thought of themselves as 'useless' or a 'burden' while over half described themselves as sad or very sad most of the time.

As social life becomes more limited, so may the ability or motivation to take on new activities or to try new things. Chinese food is very regional and people tend to prefer to eat food from their own region:

Chinese are very stubborn about food. They must have their regional food. Nothing else. The saddest thing is that the older generation are not very adaptable to cuisines. Chinese food is so readily available but they are stuck in the mind set of having to have it freshly cooked every time and if they were a bit more adaptable, they could use takeaways, restaurants. (AT)

As they get older they may be unable to prepare their own food but are dissatisfied with what is available to them, even from Chinese organisations. SPL, who runs a small sheltered housing scheme explained that residents would not eat food from other regions. She described resident from Singapore and mainland China who had moved out because they wouldn't eat the Cantonese food which was on offer.

People not only find it more difficult to learn languages as they get older, but they may lose languages they have learnt earlier in life. KOD, a psychologist, described a Chinese patient with dementia who had lost the English he had learnt earlier in his life. An additional problem is that Chinese people speak many dialects and they may lose the ability to speak other Chinese languages which they have spoken all their life. Thus they will find it difficult to communicate with each other. SPL described visiting a man in a care home:

He is a philosopher from Cambridge. And he refused to speak English. When I went there, the lady in charge said what do you want to see him for? He won't talk to you. But when I spoke his dialect he talked to me. (SPL)

The ability to communicate with someone who speaks your own language is particularly important as one gets older. WC, who runs a sheltered housing scheme for Chinese people in another borough, explained that *'They feel more comfortable in a Chinese environment'*. This is particularly important for people with dementia where a familiar environment may help them maintain some control over their lives. Some users of the Haringey Chinese Centre had developed dementia and thus needed more care but there was no alternative to mainstream residential accommodation. Their inability to communicate meant that they were very isolated:

They lasted - I think the longest was six months. Without appropriate services, unable to speak the language and with no Chinese carers, they just wither and die. (AT)

In spite of the difficulties which Chinese people face with ageing, which are often exacerbated by their lack of English and alienation from the broader society, they may still be willing to engage in a range of activities if given the right circumstances and encouragement. Chau, in a participatory research project with Chinese older people found that they were willing and able to take on different roles and levels of involvement in activities and that a feeling of ownership is key to this (Chau, 2007).

Care needs and access to services

The issues outlined above suggest that Chinese older people are likely to need considerable support but that their families are generally not in a position to provide this. Yu found that older Chinese people did not have high expectations of care from family members (Yu, 2001:9), a finding which was replicated in our study. WC, who runs a sheltered housing scheme for Chinese people in another borough described the feelings of the residents there:

Times have changed. The younger generation has changed. I think the elderly understand. They face reality. It's not like the generation before where the older people expect to look after them. These are quite understanding (WC)

Most of our respondents described receiving some support from their families. Mrs Ying's daughter had bought her a wheelchair and shares the cost of providing a carer to look after her. Most received more occasional help, such as with shopping and providing meals. Several of our individual interviewees expressed reluctance to call on family either because they lived too far away or were too busy with work or family commitments. They were also anxious not to be a burden on their families and for example Mrs Ping felt it was better to have care arranged from outside rather than trouble his family:

Of course I think it's better to be cared by a carer sent by the government⁴. I don't want to trouble my family by asking them to look after me. [...] It can cause problems for the children. They have to work and they have a life of their own. (Mrs Ping)

Chinese people thus appear to acknowledge the need for health and social care services as they get older. They may, however face difficulties in accessing appropriate services.

Health care

All our respondents had permanent residence in Britain and were entitled to free health care through the National Health Service. Chau (2008: 3) reports evidence that Chinese use health services less than other BME groups and suggests that they face exclusion due to language as well as high levels of depression and negative self-image. One of our key informants, describing a discussion with Chinese elders in Haringey suggested that many were not accessing even mainstream services:

What struck me then ... was the basic fabric of life was so dependent on communication skills within the community they were living in that basic things that you and I take for granted like accessing GPs was not on the radar. (RE)

Inability to communicate clearly makes it difficult to access appropriate treatment and many people need support in making appointments and travelling to the doctor or hospital. Obtaining this support involves being able to plan visits but, as Mr Wong suggested, this may not be available in an emergency:

For older people, you never know when they may have a problem. They could become ill any time, in particular in the middle of night; when someone help them make a call to get sent in the hospital, the doctors will have a real headache communicating with the patient, unless there's someone there to interpret for them. (Mr Wong)

⁴ Chinese people tend not to distinguish between the local authority and the government.

He described how he had been forced to try to communicate with the doctor using hand signals when they were not able to find an interpreter in a hospital.

The Healthcare Commission found that Chinese people are less likely than other groups to report positive experiences with health services (Chau, 2008: 4) which may partly reflect the inability to communicate and may increase their reluctance to use the services. Another reason for their low use of mainstream services may be that many Chinese people (including some of our individual interviewees) use Chinese medicine for particular complaints.

The low level of access to health services may also be related to attitudes to illness among Chinese people. As we saw above, Chinese people are less likely than other groups to report Limiting Long Term Illness, which may be related to attitudes to illness as much as the prevalence of disease. Tran (2006) suggests that Chinese people tend to view health as the 'absence of illness' rather than a more positive view of 'wellness'. This may cause them to be less likely than other groups to describe themselves as in poor health. As suggested above, our participants tended to see illness as an inevitable consequence of ageing and are thus more likely to use health services reactively, seeking help only when the problem has become serious, and less likely to use preventative services.

This issue is reflected in the use of community services such as dieticians, which are predominantly used by older people and are aimed at ameliorating or preventing long term conditions which impeded active life. Table 9 shows that, although Chinese people make up over 1.5% of the population in Haringey (and 0.8% of those over pension age) this is not reflected in their take up of these services.

Table 9 - People accessing Community Nursing Services in Haringey, 11/2008 - 10/2009

	Total	Chinese
District nursing	3,892	0.4%
Community Matrons	222	0.5%
Dieticians	4,633	0.4%
Foot health	2,464	0.3%
Wheelchair	95	0.0%
ICTT*	2,626	0.0%
CRT	1,662	0.1%
Community physiotherapy	5,754	0.5%

**Integrated Therapies Team, which provides rehabilitation after a hospital stay*

Source: Unpublished data supplied by Haringey PCT.

The problems involved in seeking help are particularly acute in relation to mental illness. Older people in general are more likely to find it difficult to gain appropriate access to mental health services. As one key informant in the Older People's Psychology Service said, national studies have shown that GPs don't pick up on mental illness among their patients and there are far fewer referrals of people of 65 than of people of working age. Older people, however, experience particular problems for example *'issues around retirement and loss'*. This can be particularly difficult where gender roles have been very separate and the person left when one partner dies can find it very hard to manage. Preventative services can be effective in helping people manage their distress since as KOD suggests, *to be able to come in and talk about what is happening in their life can help them to manage that next month until they come back.*

According to a briefing paper for the mental health charity Mind, Chinese people are less likely than other groups to use mental health services though they suffer more mental health problems than the general population. In addition to language barriers, Chinese people face a stigma in relation to the issue of mental illness. The Chinese Mental Health Association which provides support and advice for Chinese people suggests concepts such as 'face' and 'pride' prevent people of Chinese descent from accessing help and advice (CMA, 2009). Mental health problems 'are kept inside the individuals and relieved by gambling, alcohol or angry outbursts. Another way of hiding is to perceive symptoms as physical rather than psychiatric in origin' (Mind, 2006). As the Liverpool-

based study quoted above found, most respondents 'either hid their problem for their family or were shunned by them because of it' (ibid.).

Reluctance to access services is reflected in Haringey where only one Chinese person had accessed the Older People's Psychology Services in the past eight years. Psychology services are currently being restructured, with more emphasis on prevention and providing short periods of therapy (particularly Cognitive Behavioural Therapy) to enable people to manage their lives better. Funding constraints, however, makes it difficult to do outreach work to groups such as the Chinese according to KOD:

The issue for a service like ours is that we are a secondary mental health service and our funding is not for preventive work. As clinicians we often see the need for preventive work and there are gaps. (KOD)

The way in which the service is monitored and evaluated can also make it difficult to work with hard to reach groups.

Our service managers are keen to work with local Council's PCT and voluntary groups to address some of these gaps and we are moving towards being a bit more innovative in how we could organise things, e.g. through the library, have drop ins, organise things jointly. The new LAPT services are particularly working in these ways but their work is currently only funded with this narrow group of people who have a particular score on the anxiety or depression measures. It is more difficult to do open ended work in the community where benefits can be difficult to measure." (KOD)

These issues will be magnified in the current context of restraints on public expenditure, which are likely to become deeper over the next few years. These issues will affect social care services as well as health.

Social care services

Unlike the National Health Service, there is no national provision of social care - the support needed to carry out the tasks of everyday life -and there is a wide variety in the standards, type and quantity of support provided by different local authorities. In Figure 8 we list the main types of support people may use as they grow older, depending on the level of their need. In practice, though, for many people the care package may involve a combination of several of these and the combination changes over time. For example family members may provide forms of care alongside paid carers. Family members also often play a central role in negotiating with care providers about the appropriate care package. Moreover care often involves a combination of providers, including local authority, voluntary sector and private sector agencies.

Figure 8 - Types of support for older people

- a. **Independent or self-managing** – people manage their own needs and may adapt their lifestyle to meet changes in their mobility and general health.
- b. **Informal support** – generally spouse or children but may include friends or neighbours. This support may range from occasional help such as shopping to more extended and regular care. It is unpaid, informal and unregulated.
- c. **Support from a named carer** – a relative (often a spouse) may give full or nearly full time care which enables the person to remain in their own home. This is unpaid but a Carers Allowance can be claimed.
- d. **Domiciliary care** – paid carers provide support in managing daily tasks such as washing, getting out of bed, in the person's own home. This may be organised following an assessment through the local authority social services but will generally be provided by an agency and is paid for by the user, depending on income. The trend towards individual budgets may mean that users or their families negotiate directly with the agency although they may receive some financial support.
- e. **Other support in the home** – e.g. alarms, mobility schemes
- f. **Private care** – organised by the older person or their family through an agency or directly with an individual. In the case of the latter, there may be no monitoring and e.g. employment regulations (such as minimum wage) may be ignored.
- g. **Day care** (e.g. luncheon clubs) – provided outside the home by local authority or voluntary sector agencies, often with transport to the Day Centre.
- h. **Sheltered accommodation** – a form of supported housing for those who can manage everyday tasks independently. The individual retains an independent tenancy (or lease in the case of private schemes) and organise their own food, laundry etc. Extra support is available through a warden service, alarms and communal facilities. Domiciliary care may be provided independently of the housing scheme.
- i. **Extra care** – a higher level of support provided as an integral part of the housing scheme but people are expected to seek to become independent.
- j. **Residential care** – for those in need of high levels of care to manage basic tasks. Meals and other services are provided.

Many of our interviewees had mobility problems, felt themselves to be ageing and were fairly inactive. Most, however, valued their independence and their ability to manage themselves. Mr Chow, for example, when asked if he would like help with housework, replied:

It's too troublesome. I'd rather do it myself. I can do it better. (...) When I reach the point that I can't do it, I would be dead. I would be dead by then. (Mr Chow)

Few appeared to have thought about or planned for the future. This response was typical:

I don't know what may happen to me in the future. Currently I am OK with it. I don't need any particular assistance. I can cook for myself. I can wash the clothes. I can do the shopping. So I don't need help right now. [...] I don't think too much about the future. (...) I don't have any plan for the future. (Mrs Yuk)

As well as the desire to manage for themselves, taboos concerning ageing and death can make people reluctant to plan for old age and for example to make a will and decide where they will be buried. This can leave these issues unresolved which can be a source of distress.

A minority had regular support from family or paid carers to help them with day to day activities. For those who want to use social care services, language and communication problems

may make it difficult to get appropriate support. Many of our individual participants stressed the need to be able to communicate with a carer in Chinese and food was almost as important as Mrs Fong explained when asked what kind of carer she would need:

Someone with whom we can communicate; someone who understands our needs. Say, if you tell them that you want to eat rice porridge or noodles, they would understand it straightaway. They won't bring you bread instead. [...] ... The kids like eating bread but we older people prefer rice. (...) Young people like Western food, bread and so on. My grandchildren can eat bread. We don't need to worry about them because they are used to it. But we prefer rice. (Mrs Fong)

Negotiating with the social services department and the care agencies which have contracts to provide care can be difficult, even for those who speak English fluently and are familiar with the system as TM from the Haringey Carers' Partnership Board described in relation to her own situation:

But then you realise how long you are spending sorting out their bank account, meals on wheels, paying for things and actually it is a huge amount. Then you start having district nurses, physiotherapists, and the place is like Piccadilly Circus and you're trying to coordinate everything. (TM)

These difficulties are multiplied when there are language problems and family members may not be able to help since they may not have adequate Chinese language skills, particularly in relation to the specialist vocabulary involved in negotiating with care services. This means that help is often not sought until a crisis is reached. As RE suggested in relation to the Chinese elderly in Haringey:

Because they are not accessing those services there will be a tipping situation where there will be a sudden need to access support and the chances are that if there is a poor support mechanism for accessing mainstream services then the crisis will hit when someone rings Abe's [from the Haringey Chinese Centre] number they shouldn't be ringing because it's out of hours, but they know they can get him. (RE)

Figures supplied by Haringey's Adult Services department show that 13 social work assessments were carried out with Chinese people in 2008-09 and 10 in the year up to December 2009. A total of 31 Chinese users are currently in receipt of services such as home care, day services, equipment, adaptations and residential care. This includes all adults, not just the elderly although this group would be the main users. The figures suggest that just under one in five Chinese elderly receive support from the council. This proportion appears to be rather higher than the average for the population as a whole; Haringey Strategic Partnership reports that 11.3% of the over 65 population receive home care and that the age at which minority ethnic clients start to require this is lower than for the rest of the population (Haringey Strategic Partnership, 2009: 36).

Domiciliary care

Domiciliary care, though highly important in providing support to allow people to remain in their own homes, is a difficult service to get right. Caring work has traditionally been seen as 'women's work', a natural extension of their domestic role, and therefore requiring little training and accorded lower status than male jobs (Sales, 2007b). More formal training has been developed through vocational qualifications but caring work remains relatively low status (Datta *et al.*, 2006) and pay and career prospects are poor. Domiciliary care, however, requires high level personal skills. It often involves carrying out intimate tasks for people in their own homes and carers need to be able to form the relations of trust with clients to enable them to feel comfortable as well as sometimes be required to manage difficult or eccentric behaviour. Within an increasing market-driven system based on contracts which set out a list of tasks to be completed within set times, domiciliary care workers have little time to spare to build up these relations or to understand the specific needs of clients. RE suggested that enabling clients to provide their views on the delivery of basic personal care, including

the challenge of meeting cultural needs, appeared to be a challenge for providers and commissioners alike. The issue of communication makes building up these relationships extremely difficult for Chinese people.

There is no specialised Chinese-language care in Haringey and most of the domiciliary care provided through the council is contracted out to large agencies although some is provided through specialised agencies such as Satellite, a multicultural non-for-profit agency based in the borough. Some of our respondents had had carers who were not Chinese speakers and were not happy with the experience as Mr Chow explained:

It was too troublesome. [...] [The carer] chucked away the food in my fridge. It was food that was still good for consumption. Yet they chucked it. [...] I told him I didn't want him there anymore. I didn't want him to work for me. I asked him to leave. (Mr Chow)

In addition Chinese people also have expectations of domiciliary care which may not be possible within the contracts. As AT explained:

Chinese elderly, all they want is cleaning and cooking. Dom care is mainly for personal care, washing, dressing. But they would rather forego that and wash themselves even if it is a struggle and have the carers cooking food and cleaning which is very difficult because it is not allowed under the current contract. (AT)

Mrs Ying said that she would not want a Westerner as a carer not only because she could not communicate with them but ‘they wouldn't stay overnight’, something which would not have been possible within the normal contract. Some Chinese people thus make private arrangements with carers in order to have the sort of care they want, especially cooking. This type of care is, however, unregulated and there is no monitoring process on the quality.

Some Chinese centres, such as Camden and Lambeth, have pioneered models of domiciliary care for older people using bi-lingual carers. Camden Chinese Centre runs a ‘Housebound Project’ to support ‘frail or disabled Chinese elderly by providing them with domiciliary care and personal care so that they can live independently in their homes’. Chinese speaking carers based at the centre provide a range of services including cleaning and getting clients dressed. The project has been running for several years and is currently being reviewed as a result of feedback from users. Staff are undertaking further training in order to make them ‘familiar with aspects of their profession’. ⁵ The project has clearly encountered some of the problems inherent in domiciliary care but nevertheless provides an important model which service providers in other boroughs, such as Haringey, may learn from.

Supported housing

Some of our key informants felt that there was an urgent need for supported housing tailored to meet the needs of Chinese people, an issue raised in other research (e.g. Lambeth Chinese Community Association, 2002). There are some schemes in other boroughs. Camden has a sheltered housing project, Jubilee House, run by the Circle Anglia Housing Association which has become almost 100 per cent Chinese. It has 20 people on the waiting list and according to its manager demand is increasing as the Chinese population ages. Another, smaller scheme in Islington, the Great Wall, was initiated and still is run by a voluntary agency under the auspices of the Camden Chinese Centre.

Haringey has no specifically Chinese provision, but operates ‘key schemes’ within some of the council’s sheltered housing offering tenancies to a core group of tenants from a targeted cultural group, although the blocks are not exclusively of this group. According to an informant from the department, ‘the purpose is to develop a setting where there is a heightened emphasis on providing the service within a context that meets a community’s particular language and cultural needs, and

⁵ See <http://www.camdenccc.co.uk/english/projects/housebound.htm>

where the relevant culture is not only acknowledged but celebrated, within a multi-cultural tenant group'. Tenants from that particular culture, and the other cultures, will have made an active and positive choice to live in that setting, rather than any other sheltered setting. The council also seeks support from community centres in establishing this provision. The council has four current 'key schemes', including Spanswick Lodge which has a key scheme for Chinese. It had a total of 31 tenants in December 2009 of which 10 are Chinese. There are an additional 18 Chinese people in other forms of sheltered housing.

Most of our informants lived in their own homes or with relatives but some lived in Spanswick Lodge. Most were not concerned to have a specific Chinese facility but felt that the crucial thing was that they were able to communicate with staff, as Mrs Van said:

It shouldn't be a problem if the staff are made up of both Chinese and Westerners. But at least there are some Chinese staff; because Chinese staff understand what the residents need. Westerners may not understand so well the needs of the Chinese people. Chinese staff would understand them better. (Mrs Van)

While our interviewees felt it was crucial to be able to communicate with staff, they did not seem to be so concerned about being with other Chinese people. Mr Wong who lives in sheltered accommodation did not feel it important to be in a Chinese environment since he did not socialise with other residents:

I don't mind who the warden is, whether they are white or black or anyone else. It doesn't matter to me. As long as there is someone who can open the door for me. When I go into my room, it will be my own world. Once you are in your own room it doesn't really matter what is happening outside. (Mr Wong)

This chimes with the response of the manager of Jubilee House, who said that the communal areas were little used and residents 'prefer to stay in their own flats'. This would suggest that the important issue was to have some way of communication with staff when they needed it rather than a specifically a Chinese only facility. Sheltered housing is for people who can live independently and therefore do not necessarily need to be able to communicate with staff on a regular basis.

Several informants felt that there was a particular need for facilities for Chinese people with higher care needs. Shu Pao Lim, who established the Great Wall project, has spent many years trying to establish a residential facility for Chinese elderly in London. This would need to involve partnerships with several local authorities to make it viable and it has not been possible to develop these as yet. The manager of Jubilee House, speaking of his own residents, said:

Quite a few families have approached me about Chinese speaking residential homes. For the people who need higher level care. I think this is quite desperate. (WC)

Our own individual respondents also recognised that they might need this facility in the future and when asked how they would feel about moving into some form of residential care most were fairly philosophical about it. As Mr Lau said:

I hope to be able to stay home... But then, when it comes to the point that you cannot cook for yourself and you can't look after yourself, you might have to go there (residential care facility) anyway. Of course, this is a subject for the future. (Mr Lau)

For people in need of residential care, the importance of being able to communicate with staff is much greater than those who are more independent since it is they who will provide the care. Moreover, they are likely to be unable to go out easily and so will rely on the home to provide them with an environment in which they can feel 'at home'. The importance of a familiar environment increases as people experience memory loss through the ageing process since this particularly affects more recent memories, making more recent events seem alien.

Developing a residential home specifically for Chinese people does not seem to be a realistic proposition. Informants who know the Chinese population well estimate that the demand could be around 10-15 in Haringey and similar numbers in other borough. This would make it viable only if many boroughs were involved. One key informant also suggested that the trend of national policy is against providing facilities for specific ethnic groups.

The present political climate post 9/11 and 7/7 and the emphasis on citizenship, integration and learning English means that this is not on the agenda. (LL)

The current policy agenda in relation to social care also emphasises reducing residential provision and focussing on supporting people in their own home. Nevertheless, a minority of Chinese people will need extra care and the demand is likely to grow the rapidly ageing population. In planning provision for those in need of high levels of care, it is important that this group is born in mind. This would not necessarily need to be exclusively Chinese, but could be in the form of multiethnic centres with places earmarked for Chinese people, along with Chinese speaking staff and the facilities to cook Chinese food, together with other cuisines. This would require partnerships between community organisations and the council to plan and develop appropriate facilities. As AT suggested:

Some of the residential homes, if they could allocate half a dozen units for the Chinese, all we would have to do would be to employ a couple of Chinese bi-lingual carers. (AT)

This kind of provision would be in line with Haringey's current 'key schemes' for sheltered accommodation. The Council is currently investigating the potential for expanding this provision to other ethnic groups. This also provides a model for implementing in relation to the provision of supported accommodation with a higher level of care.

Other services

Haringey older people use a range of other services, including those provided by the Council and by voluntary bodies, both those specifically aimed at older people and more general services. A review of the general usage of these services is beyond the scope of this report, but we have obtained data on some services.

The Council Sport and Leisure services carried out ethnic monitoring of its users and the figures suggest that the percentage of Chinese among users is roughly equivalent to their proportion of the population. In the year April 2008-March 2009, Chinese people made up 1.2% of all users, and this figure rose to 1.3% in the 8 months up to October 2009. These figures are not broken down by age and it is likely that the Chinese proportion among older people is lower. It does, nevertheless suggest a positive trend and if this group continues to use these services as they age this could help them maintain an active life. Chinese people are slightly over-represented among 'active borrowers' from Haringey's public libraries, making up 2.1% of the total in 2007-8, rising to 2.3% in 2008-09. Moreover, the number of loans of Chinese books doubled in the same period.

Voluntary sector agencies of particular importance to this group include those aimed at older people such as the Haringey Older People's Forum and Age Concern, Haringey. The former provides a platform for discussing issues of concern for older people and produces a newsletter which provides information about events, policy developments and campaigns. The forum has undertaken specific events relating to the Chinese, including a dual language discussion of the needs of older people hosted by the Haringey Chinese Centre in 2009. The forum is facilitated through Age Concern Haringey, which has a joint role as service provider and advocate for older people. Age Concern's services are aimed primarily at the active elderly and their focus is on prevention through promoting involvement of older people (together with younger people) in activities. One such

activity, Fit and Active through Table Tennis (FATT) includes a number of regular Chinese participants.

For many Chinese older people, the Haringey Chinese Centre provides a major focus of their lives as it did for our individual respondents who, because of their age and frailty, were less likely to be able to participate in other activities and services. The Centre is a place where they can meet friends, chat and have a home-cooked Chinese meal as Mr Wong explained:

Some of my friends come here to meet people ... Most of them are older people. Each day you'd see over a dozen of older people here. I come here to meet them and have a chat with them. (Mr Wong)

As well as socialising, they get important practical support:

The Centre is important. Without this Centre things will not be so convenient. Staff here give advice to us and we can meet people here. (Mr Li)

If I receive a letter, I'd bring it here and ask the staff to read and explain it to me. (Mrs Yuk)

The centre runs on a limited and insecure budget and this can mean that the staff and volunteers are overstretched. There is thus a tendency to focus the services on those in most need. As RE put it:

15% of the [Chinese] population in Haringey is in contact with care providers, probably larger than that if you include unpaid carers. I would see the work of the Chinese Centre as straddling that 15% and the rest of the community but But always the tendency is to get drawn into needing to address the pointed bit of the triangle [those needing more care] and then the next layer up tends to be allowed to be less of a focus.
(RE)

A recent survey of centre users provided some evidence that uses are reasonably spread across most age groups. Nevertheless, the people who founded and supported the centre are growing older and those of working age appear less willing to or able to become involved (Bell, 2008: 1). As AT said:

I'm having difficulty in persuading the users' children – they are professional – teachers etc., to become committee members. I say I am getting old; I need new blood to take over. (AT)

The centre is thus struggling to meet these needs, particularly those of the very old who are requiring more care, at the same time as responding to new agendas including a greater focus on prevention as well as the rapidly changing population. The survey of users, however, suggested that many expressed a willingness to get involved in new activities if they had the opportunity (Bell, 2008: 14).

The policy agenda and the future of social services

The trend towards an ageing of the population, with consequent increased care needs, has brought a major policy response at national level and local level. The government is currently undertaking a review of social care services aimed at providing a 'fair, simple and affordable system underpinned by national rights and entitlements but personalized to individual needs' (DoH, 2009:9). The implementation of this ideal will be, however, complex and difficult. Moreover, there are many drivers of policy change which place contradictory pressures on services.

The existing system of social care is 'a legacy not of a single reform like NHS, but of a series of more limited and incremental steps' (DOH, 2009: 8). There is no national provision of social care and the current system is thus confusing, as the recent Green Paper on social care, *Shaping the Future of Care Together*, acknowledges. It is often difficult for people to negotiate, especially for those whose English language skills are not good.

Current policy makes a sharp distinction between medical and social care. Treatment for medical conditions is available free through the National Health Service while social care is available free only to those on very low incomes and with limited assets. In spite of this important difference, the line between medical and social conditions is in reality extremely blurred. Alzheimer's disease, for example is a medical condition which causes people to lose the ability to look after themselves but the support needs it generates are generally seen as 'social care' and therefore not paid for through public funds.

Increasing recognition of the interconnection between social and health care with an ageing population has led to the establishment of a ministerial group on the integration of Health and Social and a proposal for a National Care Service which would work closely with the NHS. This development is, however, happening at a time of political consensus across the main political parties against raising personal taxes significantly and, following the banking crisis of 2008-2009, increasing pressure to cut public spending. The government has ruled out a predominantly tax funded system which it claims would place too great a burden on the diminishing proportion of the population currently in work. In order to square the circle of increased need and lower spending, it proposes both to make services more efficient and to reduce the need for higher end care through prevention of disease and the promotion of independence.

These various strands of policy have been in place for many years in relation to social care but will be given added impetus within the new framework. The period following the Second World War saw a major shift from institutional care towards providing care for elderly people in their own homes (DoH, 2009: 33) a trend intensified by the Community Care Act, 1990 (Ryan et al, 2009). Local authorities became 'care managers' for clients but the actual provision of care became more fragmented as local authorities contracted out their own services to private providers. Councils tend to commission services from a small number of large private agencies, but some are commissioned from voluntary agencies. In Haringey, for example, about 80% of home care is contracted out, mostly through block contracts to two large providers, but the council uses other agencies if these providers are not able to meet specific needs such as culturally appropriate services for particular groups. Individuals or their families have also been encouraged to negotiate their own care arrangements through the development of individualised budgets thus distancing councils even further from the direct provision of services.

As local authorities have faced restrictions on their budgets, their assessments have increasingly focused on ability to pay as well as need, such that, as the charity Counsel and Care suggest 'only those older people with the highest dependency needs, without any available support and on low incomes, will get council services' (Counsel and Care, 2008). This has led to reduced subsidy for services such as luncheon club which can deter users, as AT explained:

Now the Council policy is much more stringent in relation to assessment and they are imposing charges. Many elderly people if you say we charge you £10 will prefer to stay at home as the food only costs £2 or £3. We have lost quite a few elderly users because of these charges. (AT)

Moreover, the shortage of resources has meant pressure to cut costs, of which the most significant is staffing. Staff working in this sector are already low paid but there is pressure to reduce the time that they spend with each client. They are required to complete a pre-ordered set of tasks within a particular time frame rather than being able to provide the more intangible aspects of care such as sharing a cup of tea (Datta et al, 2006).

Financial constraints have also affected the fees which local authorities pay for residential care were in most cases below the actual cost of residential and care provision, meaning that the older person or their relatives was obliged to pay top-ups. This has meant that smaller and not-for-profit providers have found it difficult to survive within the market so that residential care has become dominated by a smaller number of large private providers (Wanless, 2006: 23).

The Wanless Review into social care which reported in 2006 promoted the idea that people should remain in their own homes for longer through the provision of domiciliary care and preventative services. This report laid the foundations for greater cooperation between health and

social care agencies (DoH, 2009: 33). The 2009 Green Paper sets out some proposals for implementing a new care system. A key aspect is the promotion of 'best value' which it is claimed will provide better services within a reduced budget.

Another development, as part of the process of *Transforming Social Care* (DOH, 2008) is the extension of the individualisation of care packages by providing individuals – or their carers – with the right to assess their own need, with assistance from social services (. Councils are required to develop a model which allows the needs which have been identified for each individual to be translated into a specific sum of money, an 'individual budget', in order to ensure consistency between different users. The individual budget can then be used to develop a support plan which the person can develop themselves or with assistance. This plan may involve a range of services including for example traditional domiciliary care services.

Preventative strategies have been given a higher priority in the white paper and some aspects have been introduced – albeit in piecemeal fashion – through various policy initiatives over recent years. They involve a range of policy areas including most importantly health but also such services as leisure and transport. The national Health of Older People Strategy includes health checks for all those between 40 and 74 year old in order to identify, and provide early intervention for, diseases such as cardiovascular problems. These checks will take place in GP surgeries and other venues which provide scope for using them as the basis for reaching out to people who are not regularly in touch with mainstream services. The result of the checks may lead to referrals for further treatment or to the provision of advice on prevention. Other interventions have included healthy eating programmes and the promotion of exercise for example through the free swimming sessions for the over 60s provided by some local authorities. The free travel on public transport for the over 60s, initiated in London but now a national scheme for buses, also plays an important preventative role, helping older people to maintain their activities and social contact.

Implications for minority ethnic groups

This policy agenda raises a number of specific issues for minority ethnic groups such as the Chinese. It may offer the possibility of developing more appropriate, culturally sensitive services, with for example carers who speak the language of clients. This could mean more commissioning from culturally appropriate services which enables councils to reach out to groups like the Chinese which have been relatively neglected up to now. This process would lead to greater involvement of community groups as providers of contracted services through the development of social enterprises which would allow the use of the resources, knowledge and expertise of these groups. Some organisations, however, may find it difficult to respond to this shift, especially smaller ones with limited resources and have thus tended to respond to immediate need rather than be able to plan strategically. Moreover, this process can entrench divisions as particular organisations are perceived as meeting the needs of 'their community' and could mean that assumptions about what is best for particular groups become more entrenched.

The new system is also likely to make what is already a complex process for users and carers to negotiate yet more complex. The introduction of individualised budgets shifted more of the burden for planning and monitoring care onto the individual and their families. This has important implications for groups who may have very little English or understanding of the role of social care services. AT from the Haringey Chinese Centre was forthright in expressing his concern at the development of individualised budgets:

The government gives them money to manage their care budget themselves. This is the greatest set back as far as I am concerned. They give the money to the people who are vulnerable, may not be able to manage it, may be susceptible to abuse/exploitation or do not necessary have enough knowledge to manage.... And the most worrying part is the lack of control and accountability on the standard of care provided as some may employ friends or relatives or others who have not necessary registered with the appropriate authorities and have not had CRB checks. (AT)

The proposal to allow individuals to develop their own support plan, though opening up the possibility of more imaginative and appropriate forms of care, is unlikely to be workable for those with limited English and knowledge of how the care system works. The process of developing the new model is at an early stage and many issues concerning its implementation have not been thought through. Many people need support in order to access universal services and require a strong advocacy service to help navigate their way through complex care systems (RE). The new system, which places so much more onus on the individual client, is potentially even more difficult to negotiate.

The focus on preventative work, while a positive development, can only be successful in relation to minority ethnic groups (and other excluded groups, particularly those on low income) if it is accompanied by outreach work to contact those who have difficulties in accessing services. This will require new forms of partnership between groups such as the Haringey Chinese Centre and health and care services.

Developments in Haringey

Social care services in Haringey have been given a higher priority than in the past (Haringey Council, 2007: 14) and the restructuring of council services to place leisure services within social services was expected planned to provide a focus on well-being which is wider than traditional social care (ibid: 15) and emphasises preventative work as well caring services.

Haringey, like other boroughs, is currently developing a response to the new policy agenda. It has produced a number of documents which set out estimates of future need and proposals for a policy response. These include discussion of the needs of particular groups but Chinese, although included (together with 'other') as a category in the ethnic breakdown, are not specifically mentioned in any of these documents. It is important that the needs of this 'invisible' group are taken into account.

The council is also developing the framework for the new world of individualised budgets. This necessitates putting into place a whole series of mechanisms and the development of new teams to assist with developing needs assessments and support plans and the monitoring. These processes are still being developed and it is not yet clear how they will work.

The drive towards maintaining people in their own homes for as long as possible means the replacement of residential homes with domiciliary care to support people in their own homes. It is planned that the council will provide residential care only for those with specific needs such as dementia. Some people, however, will need high levels of care – either temporarily following an illness or permanently. The Council has estimated that there will be a substantial increase in the number of extra care places to replace residential care (see Table 10).

Table 10 - Haringey - Likely number of extra care places needed from 2008

	2008	2013	2018	2023	2028
Additional no of extra care places required due to planned reductions in residential care	34	120	Fixed at 172	Fixed at 172	Fixed at 172
Projected number of people likely to be receiving ten plus hours personal care aged 70+	288	296	315	335	356
Total estimated number of extra care places required 2008-28	322	416	487	507	528

Source: Assessment of Older People's Needs in Haringey (2009: 29)

It is acknowledged, however, that this provision is not as yet well developed as other aspects of social care. There is an urgent need for this kind of extra care among a small number of Chinese people.

Their numbers are not large but without appropriate provision, including access to Chinese speaking carers, they face a very bleak prospect.

The current situation thus provides opportunities for improving services and increasing the access to them by groups such as the Chinese, particularly in relation to preventative services. This will, however, only come about if the specific needs, and the obstacles to access, are acknowledged and ways of responding to this situation are built into the planning of future services. Below we discuss some specific policy recommendations.

Conclusions

The care needs of the Chinese population present serious challenges to policy makers in Haringey, as in London and Britain as a whole, which are likely to increase over the coming years. The Chinese population is ageing and is also becoming more diverse, reflecting different waves of migration. Recent migration, for example, has included more Mandarin speakers, while the longer established population, and the organisations and services which they have established, is dominated by Cantonese speakers.

The Chinese population has been relatively invisible in relation to the policy agenda with a low public profile and record of engagement in political life in Britain. There is thus an urgent need to acknowledge this group and their specific needs in order that they can be taken into account in the planning of services.

Chinese people have tended to be seen as economically successful and self-sufficient and thus not making demands on the state. The experience of migration and settlement, however, with for example long working hours and changing family structures, means that family members are often unable or unwilling to provide for the care of elderly family members. There is often a large generation gap which may be exacerbated by difficulties in communication between parents and children. Older people have often had limited opportunities to learn English while their children may not have been able to acquire fluency in Chinese languages, especially in relation to more complex exchanges such as those relating to services. This also means that children are not able to act as interpreters or advocates for their parents in relation to service provision.

Older people frequently expressed the desire not to be a 'burden' on their children. Although many of our respondents felt that they would prefer to maintain their independence as long as they could, they would often prefer to accept care from the local authority or Chinese organisations.

Chinese older people experience the same kind of problems faced by other groups as they age but these can be exacerbated by:

- Poor English skills which reduce their ability to engage with mainstream society. Some have never had the opportunity to learn English while for others language may have been lost through for example dementia or strokes;
- The diversity and scattered nature of the Chinese population means that individuals may also be isolated from other Chinese people and from Chinese organisations. There are few focal points for community engagement as other groups have for example around religious institutions;
- High levels of poverty due to concentration in low skilled employment and lack of knowledge of entitlements to benefits and pensions;
- High levels of work related illnesses such as arthritis;
- Taboos about ageing and death which may deter them from planning for the future.

Chinese people tend to have a low level of access to mainstream services, particularly preventative services, since:

- Poor English skills and lack of understanding of the services which are available and for example how the National Health Service operates;
- Many are illiterate in Chinese as well as English so they are unable to read translated material;

- Stigma and shame in relation to issues such as mental illness, domestic violence and certain illnesses (e.g. cancer) prevent them seeking help and support, particularly at an early stage;
- Many Chinese people's lives have involved little choice, including the decision to migrate, and they may therefore have little experience of making choices for themselves, particularly in areas which are not seen as necessities. They tend to see themselves as 'old' at an early age and may be reluctant to take on new interests;
- Problems of communicating with service providers can lead to poor experiences of the health and social care services;
- Inappropriate and insensitive services can make people reluctant to access them. Beliefs and understandings about health may differ from those of mainstream western medicine.

Chinese community organisations play an important role in providing care, advice, referrals and social support. The Haringey Chinese Centre was a vital part of the lives of many of our participants. Community organisations, however, face a number of pressures. Like all voluntary sector agencies, however, their funding is insecure and often inadequate for the needs they seek to address. There tends to be pressure to respond to the most severe needs and to respond to emergencies. This limits the ability of long term planning. Moreover the focus on this kind of activity tends to reinforce dependency and reduce active participation. As the generation which founded and run these groups themselves age, there is a need for new younger people to participate but the generation gap in terms of life style and language make it difficult to attract new volunteers and participants. There is a need for continued support and partnerships in order to maintain current activities but also to widen the range of what is offered. Many service users expressed an interest in participating in such activities.

The reorganisation of health and social care services – nationally and in Haringey – brings potential challenges as well as opportunities. In spite of the greater emphasis on independence, there remains a need for a range of care provision, including domiciliary care, supported housing and 'extra care', particularly for the older age group whose caring needs are most severe. This needs to include provision for appropriate language and other cultural support. Preventative strategies need to be targeted towards ethnic minority groups, including Chinese, if they are to be successful. It is crucial that their needs and aspirations are taken into account in the planning of services.

Recommendations

Service Providers

1. **Acknowledging the needs of Chinese people** in the planning of services. This is most pressing in relation to specific services for the elderly but also needs to include services used by the general population in order that Chinese people become comfortable to accessing appropriate services and maintain and develop ways of engaging with the wider population.
2. **Promoting awareness** among service providers about issues concerning Chinese people and care e.g. health beliefs, regional differences, migration history.
3. **Targeting services to the most excluded groups** especially those who are illiterate and/or are non-English speakers through for example:
 - use of Chinese venues for events e.g. screening/health checks, showing of health promotion videos in Chinese, talks by Chinese speakers on health-related issues;
 - provision of information in Chinese in GP surgeries and health centres, including leaflets on specific issues e.g. the structure of the NHS and their rights, specific health issues;
 - provision of information, including through face to face contact, at other places frequented by Chinese people e.g. Chinatown, Chinese shops.
4. **Supporting community organisations** to ensure the continuity of services and activities and projects and to develop further initiatives through:
 - Providing funding to maintain the infrastructure of the organisation and to support particularly initiatives;
 - Maintain support for culturally specific services e.g. luncheon clubs;
 - Providing suitable premises for events initiated by/with community organisations;
 - Helping to facilitate events through for example providing speakers, other expert assistance;
 - Giving prominence to community activities in Council publications/website.
5. Taking account of the needs of Chinese in planning **accommodation**, especially supported housing for the elderly.
 - The 'key scheme' for sheltered housing should be maintained and extended to ensure that language and cultural needs are taken into account in the allocation of sheltered accommodation. Where possible, staff should be available who are able to speak a Chinese language .
 - Provide urgently new 'extra care' places including culturally specific places with care staff able to communicate in Chinese languages.
 - Information and advice about adaptations which are available to enable people to live in own homes needs to be made available to Chinese people.
6. Expanding the number of **Chinese speaking carers** in both domiciliary and institutional settings.
 - Social services, in partnership with Chinese organisations and other agencies, should seek to recruit and train Chinese speaking carers
 - The experience of Chinese speaking carers' services (e.g. in Camden and Lambeth) should be investigated as potential models, in partnership with the Haringey Chinese Centre.

7. Supporting **Chinese unpaid carers** through the provision of:
 - Advice and information on support services, carers' rights;
 - Respite care
8. **Communicating with Chinese service users** through:
 - Provision of interpretation services (e.g. telephone help line)
 - Initiating discussion with older people (in partnership with community/voluntary organisations) about issues concerning interpretation, getting their feelings/symptoms understood
8. **Commissioning and supporting further research** into the needs and experience of the Chinese elderly, e.g.:
 - Wider studies of the social and economic conditions of the Chinese population
 - Prevalence of particular diseases;
 - Attitudes to service development

Chinese organisations (e.g. Haringey Chinese Centre)

9. **Promoting opportunities for engagement with the wider population**
 Chinese organisations such as the Haringey Chinese Centre may consider extending and reshaping their services in order both to support those with high care needs and to work on more preventative strategies to promote active life. This may involve the development of partnerships with other community and voluntary organisations and include activities such as:
 - English language classes and other adult education classes for example computing
 - Joint events for example on health promotion; financial advice.
 - Joint activities e.g. keep fit, music, social events
 - Involvement with local campaigns to ensure that the Chinese voice is heard; engaging with local issues concerning older people and their rights
 - Raise the profile of Haringey's Chinese population and Chinese organisation in the area through for example advertising in local media, opening events to a wider population, engagement with local organisations.
10. **Maintaining and developing services for Chinese people with high care needs through:**
 - Maintenance of the luncheon club and advice and assistance
 - Targeting those with higher needs through for example outreach workers to identify the housebound
 - Development of a befriending services for housebound elderly
 - Ensure that service providers, particularly GPs are aware of specific issues which may be faced by Chinese population
11. **Developing activities aimed at promoting active life** through:
 - Organising events to help in planning for retirement (with other Chinese and non-Chinese organisations)
 - Targeting the younger post-retirement group with information and support to encourage them to participate in social activities/exercise in order to maintain activity and independence.
 - Establishing partnerships with service providers and commissioners to ensure that the needs of Chinese people are taken into account in planning services;

- Developing their role as social enterprises in order to develop targeted services;
- Extending the range of their activities in order to:
 - a. engage younger generation – the Chinese school provides a basis for contacting young people and their parents
 - b. focus on activities which promote active engagement and learning
 - c. provide activities such as computer skills to enable older people to maintain contact with family and friends, especially those who do not live locally
- Build links with other Chinese organisations e.g. specialist organisations like Chinese National Healthy Living Centre in order e.g. to share information, provide special sessions
- Encourage members to participate in activities organised by both Chinese and mainstream organisations (e.g. Age Concern/HAVCO)
- Promote awareness among the mainstream Chinese population about issues concerning the older population, mental health issues,

12. Participate in the planning of services for Chinese older people through

- Involvement in relevant partnerships, forums and other organisations
- Promoting discussion among the wider Chinese population about how they would like to see the future development of services

Other voluntary sector organisations

13. Engaging with Chinese population through seeking to recruit and involve Chinese people in activities, e.g.:

- Organise joint activities with Chinese organisations on issues of interest
- Ensuring that information about activities is available to Chinese people through e.g. making it available at Chinese venues, where possible translating into Chinese
- Seeking, with Chinese organisations, ways of making their services more accessible to Chinese people, e.g. by recruiting to identified volunteer roles

14. Plan ways to increase the uptake of Quality-Marked Information and Advice by Haringey's older Chinese population

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Appendix I – List of Key Informants

- Lincoln Lim, **Camden Chinese Community Centre**
- Waiman Cheung, Manager, **Jubilee House Sheltered Housing**
- Shu Pao Lim, **Chinese Community Centre / Great Wall**
- Robert Edmonds, **Age Concern**, Haringey
- Kathryn O'Donnell, **St Ann's Hospital**, Psychology Services for the Elder
- Abe Tse, Director, **Haringey Chinese Centre**
- Toni Mallet, **Haringey Councillor**
- Barbara Nicholls, Head of Commissioning, **Adult Services, Haringey**
- Susan Otit, Associate Director of Public Health, **NHS Haringey**
- Delia Thomas, Service Manager, Central Locality, **Adult Services, NHS Haringey**

Appendix II – Characteristics of individual interviewees

Summary of main characteristics:

- Gender: Females: 8 ; Males: 7
- Age groups:
 - 60-69: 4
 - 70-79: 8
 - 80-89: 2
 - 90-94: 1
- Country of origin: China: 9 ; Hong Kong: 6
- Year of arrival in the UK:
 - 1960-1969: 5
 - 1970-1979: 6
 - 1980-1989: 2
 - 1990-2003: 2
- First language/dialect: Cantonese: 13 ; Hakka: 2
- English ability: None/almost none: 10 ; Basic communication: 4 ; Good: 1
- Marital status: Widowed: 9 ; Single: 2 ; Married: 4
- Where are the children (if any): London: 8 ; UK and abroad: 2
- Any paid work in the UK: Yes: 11 ; No: 4
- Occupation before retirement:
 - Chinese restaurant worker: 9 ;
 - Chinatown supermarket worker: 1
 - Chinese Restaurant Owner: 1
 - Care worker: 1
 - Worker in paddy fields in Hong Kong: 2
 - Accountant/Admin worker in Hong Kong: 2
- Receiving benefits: 15

Profile of individual interviewees

Individual's ID	Age Group	Gender	Country of origin	Decade of arrival in the UK	Any paid work in the UK	Occupation before retirement	Marital Status
Mrs Ying	80 – 89	Female	Hong Kong	1970s	Yes	Dishwasher	Widowed
Mr Man	60 – 69	Male	China	1960s	Yes	Catering	Married
Mrs Chan	90 – 94	Female	China	1970s	No	Farmer	Widowed
Mrs Lan	80 – 89	Female	Hong Kong	1980s	No	Farmer	Widowed
Mr Lau	70 – 79	Male	China	1970s	Yes	Catering	Married
Mrs Fong	70 – 79	Female	China	1990s	No	Accountant	Married
Mr Chow	70 – 79	Male	Hong Kong	1960s	Yes	Catering	Widowed
Mr Cheung	70 – 79	Male	China	2000s	No	Admin	Married
Mr Li	70 – 79	Male	China	1960s	Yes	Worker in a supermarket	Single
Mrs Ping	60 – 69	Female	Hong Kong	1960s	Yes	Catering	Married
Mrs Mui	70 – 79	Female	China	1970s	Yes	Dishwasher	Widowed
Mrs Yuk	70 – 79	Female	Hong Kong	1970s	No	Farmer	Widowed
Mr Wong	60 – 69	Male	China	1980s	Yes	Catering	Widowed
Mrs Van	60 – 69	Female	China	1970s	Yes	Care worker	Widowed
Mr Ma	70 – 79	Male	China	1970s	Yes	Waiter	Single